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# Rule 11: Has the Objective Standard Transgressed the Adversary System ?

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# Notes

## THE APPLICABILITY OF EXPERIENCE RATING TO MEDICAL MALPRACTICE INSURANCE

*The medical malpractice crisis has continued to exact significant costs from the medical community. In an effort to solve the problem of decreasing availability of affordable insurance for the practitioner, two states have introduced merit-based rating of physicians. This Note analyzes the New York and Massachusetts plans of experience rating and concludes that the subjectivity which is incorporated into the MLMIC of New York plan is more desirable, especially from the standpoint of the physician.*

### INTRODUCTION

The current upheaval in the area of medical malpractice has inspired demands for change and a vast array of proposed solutions from physicians, attorneys, insurers and legislators. Concerns over rising costs and their concomitant effect on the quality of health care have motivated many of the changes. The debate continues, and as of yet, no panacea has been found to remedy this "crisis."<sup>1</sup> Solutions range from a panoply of state-enacted tort reforms<sup>2</sup> to suggestions for improved physician monitoring and penalization of

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1. The term "crisis" in the area of medical malpractice insurance seems to encompass various interpretations depending on one's frame of reference (insurer, physician, or lawyer, etc.). For example, "the term 'crisis' denotes a crucial, unstable condition in which abrupt, drastic change is impending." AM. BAR ASS'N SPECIAL COMM. ON MEDICAL PROFESSIONAL LIAB., REPORT TO THE HOUSE OF DELEGATES, commentary at 29 (Feb. 11, 1986) [hereinafter ABA COMM.] (the committee felt the term was inappropriate with respect to the medical malpractice insurance situation). Furthermore, a "crisis" in the medical malpractice context has specifically referred either to problems of "availability," "affordability" or both. See AM. MEDICAL ASS'N SPECIAL TASK FORCE ON PROFESSIONAL LIAB. AND INSURANCE, PROFESSIONAL LIABILITY IN THE 80'S, REPORT 1 at 4-11 (Oct. 1984) [hereinafter AMA TASK FORCE, REPORT 1]; Posner, *Trends in Medical Malpractice Insurance, 1970-1985*, 49 LAW & CONTEMP. PROBS. 37, 38, 49-52 (1986); *Hearings Before the Wisconsin Legislature Joint Comm. on Medical Malpractice* (Feb. 26, 1986) (testimony of Dr. Claude C. Lilly, Director of the Center for Insurance Research at Florida State University); See also P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* (1985) (comprehensive discussion of causes and cures for availability and affordability problems in medical malpractice insurance).

2. See generally Essen & Aldred, *The American Medical Association vs. the American Tort System*, 8 CAMPBELL L. REV. 241 (1986) (discussion of damage caps, restrictions on attorney contingency fees, elimination of the collateral source rule, and payment of damages by installment); Rust, *23 States OK'd Reforms in '86*, AM. MEDICAL NEWS, July 25, 1986, at 1, col. 1.

negligent practitioners via the appropriate disciplinary mechanisms of groups such as state licensing boards and hospital peer review groups.<sup>3</sup>

A suggestion which seems to be derived from the latter notions of punishment and deterrence<sup>4</sup> is the application of experience or merit rating<sup>5</sup> to medical malpractice insurance as it has been used in the automobile insurance industry.<sup>6</sup> This approach would impose higher malpractice insurance premiums on physicians with poor track records during the previous insurance term, and rewards in the form of premium reductions to those with no incidence of negligence.<sup>7</sup> This Note will first examine the medical malpractice insurance industry's current state of affairs and then delve into its system of classifying physicians for premium determination. It will then introduce an alternate method of premium determination based on experience rating and set forth two states' recent efforts at experience rating: the New York and Massachusetts plans. The final section will analyze these plans in light of possible benefits and potential concerns.

## I. BACKGROUND

The current state of alarm in the area of medical malpractice is not unprecedented.<sup>8</sup> In the mid-1970s, physician malpractice insurance premiums soared, with some carriers implementing increases as high as 500 percent.<sup>9</sup> Other insurers elected to withhold coverage or to abandon the malpractice segment of the market altogether, thereby making coverage for some physicians impossible to secure at any price.<sup>10</sup> The apparent cause of the 1970's crisis was a sharp rise in costs per claim between 1969 and 1974 as the result of

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3. See S. Wolfe, H. Bergman & G. Silver, *Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform* i, iii, 4, 5 (Aug. 27, 1985) (unpublished report printed by the Public Citizen Health Research Group) (advocates discipline of incompetent practitioners as the solution to the crisis in medical malpractice insurance); Hinz, *MD License Revocations up 34% in '85*, *Am. Medical News*, Nov. 21, 1986, at 1, col. 1; cf. AM. MEDICAL ASS'N SPECIAL TASK FORCE ON PROFESSIONAL LIAB. AND INSURANCE, *PROFESSIONAL LIABILITY IN THE '80's*, REPORT 2 at 8, 10 (Nov. 1984) [hereinafter AMA TASK FORCE, REPORT 2] (insurers comment that criticism of physician discipline is unjustified).

4. See *infra* notes 153-69 and accompanying text.

5. See *infra* notes 71-80 and accompanying text.

6. See *infra* text accompanying notes 74-78 & note 165.

7. See generally sources cited *infra* note 158.

8. Posner, *supra* note 1, at 38.

9. *Id.*; P. DANZON, *supra* note 1, at 85.

10. P. DANZON, *supra* note 1, at 85; Posner, *supra* note 1, at 38; Steves, *Medical Professional Liability*, in *PROFESSIONAL LIABILITY: IMPACT IN THE EIGHTIES* 94 (1983).

an increase in the "severity" and "frequency" of malpractice claims during that time period.<sup>11</sup> A variety of theories have been propounded to explain why the insurance industry did not react sooner to the changing climate of malpractice litigation in the early 1970s and adjust premiums accordingly before such drastic measures became imperative in 1975.<sup>12</sup>

In response to the 1970s crisis, remedies focused on state tort law reforms<sup>13</sup> and several fundamental changes within the insurance system.<sup>14</sup> Although exorbitant premiums were cause for concern among physicians, insurance "availability" problems posed an even greater threat of disruption to the medical profession and to health care delivery.<sup>15</sup> The abandonment of medical malpractice coverage by insurers, creating the availability problem, has been traced to state regulation or lack thereof.<sup>16</sup> As a result, many states developed alternative mechanisms to fill the void created by the desertion of these commercial carriers.<sup>17</sup> Joint underwriting associations (JUAs) were established in many states as a means of assuring availability.<sup>18</sup> The JUA imposes a sort of compulsory compromise on insurers. In order to engage in the sale of the more lucrative and less risky forms of insurance, the carrier must agree to participate in medical malpractice coverage as well.<sup>19</sup>

Another alternative was the birth of the physician-owned insur-

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11. P. DANZON, *supra* note 1, at 98; M. REDISH, LEGISLATIVE RESPONSE TO THE MEDICAL MALPRACTICE CRISIS: CONSTITUTIONAL IMPLICATIONS 3 (1977); Posner, *supra* note 1, at 38-39; Steves, *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*, in MEDICAL MALPRACTICE: THE DUKE LAW JOURNAL SYMPOSIUM 143 (1977).

12. P. DANZON, *supra* note 1, at 99-103. "[T]he most commonly cited factor was ignorance, allegedly resulting from lack of data and unanticipated changes . . . [plus] three other possible contributing factors: federal price controls, state regulation, and competition." *Id.* at 99.

13. See generally M. REDISH, *supra* note 11 (analysis of the constitutional ramifications of the state revisions which were a response to the 1970s crisis).

14. See *infra* text accompanying notes 17-32.

15. See sources cited *supra* note 1 (regarding the "availability" crisis).

16. P. DANZON, *supra* note 1, at 107-08. "Denial of requested rate increases or approval of the claims-made form, or both, were directly responsible for the withdrawal of the group carrier in [some states]." *Id.* at 108. For an explanation of claims-made policies see *infra* text accompanying notes 23-32.

17. See P. DANZON, *supra* note 1, at 109.

18. AMA TASK FORCE, REPORT 1 *supra* note 1, at 5; P. DANZON, *supra* note 1, at 85, 107, 111-12; Posner, *supra* note 1, at 41; Steves, *supra* note 10 at 94.

19. P. DANZON, *supra* note 1, at 85, 112. Although JUA's were not viewed as a long term solution to the 1970s availability of insurance problem, they continue to exist. *Id.* at 85, 112, 113. In fact, last year, Virginia's JUA was revived after an independent carrier eliminated malpractice coverage. *Liability Insurance: The Squeeze on M.D.s Will Get Tighter*, MED. ECON., Nov. 10, 1986, at 197.

ance company or "mutual."<sup>20</sup> In the seven years after the 1975 crisis, almost forty of these companies were created<sup>21</sup> with the hope that physician involvement would provide invaluable expertise and understanding to the problems of medical malpractice insurance.<sup>22</sup>

Finally, the crisis of the 1970s inspired the development of the "claims-made" policy as an alternative to the previously prevalent "occurrence" policy.<sup>23</sup> The latter coverage protects the physician from liability resulting from an episode of alleged malpractice which *occurs during* the policy term, irrespective of when recovery is ultimately sought.<sup>24</sup> The claims-made policy, on the other hand, insures against claims *instituted during* the policy term.<sup>25</sup> This type of policy provides some clear advantages in terms of predictability for the insurer.<sup>26</sup> Because of lengthy delays between an occurrence and the ultimate resolution of a claim, which may take years, insurers using the occurrence form are confronted with the challenge of predicting the economic implications of possible future claims.<sup>27</sup> They must set premiums today which will cover the claims of tomorrow. By using the claims-made policy, the insurer seemingly narrows this gap by covering claims rather than occurrences, thereby eliminating much of the predictability problem. The resulting savings may then be passed on to the consumer in the form of lower premiums.<sup>28</sup> The claims-made policy, however, is not without its critics. Much of the criticism focuses on the vulnerability of

20. AMA TASK FORCE, REPORT 1, *supra* note 1, at 5; P. DANZON, *supra* note 1, at 109-10; Posner, *supra* note 1 at 39-40; Steves, *supra* note 10, at 94-95.

21. Posner, *supra* note 1, at 39 (citing AM. MED. ASSURANCE CO., 1985 USA DIRECTORY—PHYSICIAN-OWNED, MEDICAL SOCIETY-CREATED PROFESSIONAL LIABILITY INSURANCE COMPANIES (9th ed. 1985)).

22. *Id.*; P. DANZON, *supra* note 1, at 128-29.

23. P. DANZON, *supra* note 1, at 85, 91-92; Posner, *supra* note 1, at 44-45; Steves, *supra* note 10, at 96-97.

24. *Id.* at 91-92, 110. Therefore, even if the physician is no longer currently insured by the carrier, he is still covered for any claims arising from his activities during the time period in which he was insured under that policy.

25. P. DANZON, *supra* note 1, at 110; Posner, *supra* note 1, at 44; Steves, *supra* note 10, at 97. According to Steves, a claims-made policy is triggered:

when a third party notifies an insured that redress for an injury is being sought. The receipt of a call from a claimant or a letter or summons from the claimant's legal representative is what is meant here in the strictest sense. However, . . . [f]requently, what is defined as claims-made includes any incident reported to the insurer within the policy period irrespective of whether a third party is involved.

*Id.*

26. Posner, *supra* note 1, at 44-45; Steves, *supra* note 10, at 98.

27. Posner, *supra* note 1, at 45.

28. P. DANZON, *supra* note 1, at 111; *cf.* Steves, *supra* note 10, at 98 (cost advantages of claims-made coverage are not well documented).

the insured.<sup>29</sup> As opposed to an occurrence policy where the insurer bears the brunt of the risk that the premiums of today will be sufficient to pay the claims of tomorrow, with a claims-made policy, the insured bears the risk that if costs rise today, so will his rates. "By offering claims-made rather than occurrence insurance, the company effectively transfers the risk of uncertainty concerning future price increases back to the insured, who is in a much less advantageous position to evaluate this uncertainty."<sup>30</sup> In other words, the impact on the physician's premiums of rising costs to the insurer becomes much more immediate and perhaps unanticipated. The so-called transfer of uncertainty is in effect a transfer of the risk of current malpractice cost increases. Furthermore, the physician who terminates a claims-made policy must often make special provisions for coverage of claims *filed after* the policy's termination date.<sup>31</sup> These "tail" coverage policies are generally available at an additional premium from the claims-made insurer, however situations vary.<sup>32</sup>

Despite the remedial measures inspired by the last crisis, there again seems to be cause for concern. At the threshold of the current debate is whether in fact another "affordability crisis"<sup>33</sup> exists today in medical malpractice to justify the extensive mobilization of resources and implementation of reforms which have taken place. While the answer to this question is a resounding "yes" from many commentators,<sup>34</sup> others suggest that physicians are not overburdened by malpractice premiums, but rather, they are paying as they should for the serious losses they cause when negligent.<sup>35</sup>

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29. See Steves, *supra* note 10, at 101.

30. *Id.*

31. *Id.* at 97.

32. *Should You Buy Tail Coverage?*, MED. ECON., June 23, 1986, at 53. "[T]he cost of the tail is usually 150 to 200 percent of the current annual premium. For many OBG's, [obstetrician-gynecologists] that's a lump sum outlay of \$40,000 to \$50,000 or more. . . ." *Id.*

33. AMA TASK FORCE, REPORT 1, *supra* note 1, at 8, 10. Increases in liability premiums exceeding 80% over an eight year period have created a situation with which the president of the Physician Insurers Association of America sympathized. "We need adequate rates of coverage and sometimes are forced to collect obscene premiums that continue to climb." *Id.*; ABA COMM. *supra* note 1, at 27 ("[T]he medical profession's primary focus [of debate] is on affordability.") See Posner, *supra* note 1, at 37-38.

34. See *Joint Commission on Insurance Hearing on Medical Malpractice* (Mar. 19, 1986) [hereinafter *Hearing*] (testimony of Barbara A. Rockett, M.D., President of the Massachusetts Medical Society before the Massachusetts Joint Commission on Insurance).

35. Sargeant, *Blame Negligent Doctors, Not Insurance*, Boston Globe, Apr. 3, 1985, at 15, col. 2; see also ABA COMM., *supra* note 1, commentary at 27-29 (expressing the opinion that tort law should not be blamed for the alleged problems in malpractice insurance and that pervasive reforms are not the solution).

Whether the current problems are perceived as a "new crisis" or merely a continuation of the old, there has been a renewed clamoring for change. Based upon available data regarding the number of malpractice claims being filed against physicians,<sup>36</sup> the size of awards,<sup>37</sup> and the escalating cost of malpractice insurance,<sup>38</sup> it is at least arguable that the current uproar is not unfounded.<sup>39</sup>

Before 1981, an annual average of 3.2 claims were brought per 100 physicians, and by 1985, the incidence had more than tripled to an average of 10.1.<sup>40</sup> The figures for particular specialty areas are even more striking. Before 1981, an annual average of 4.1 claims were filed per 100 surgeons,<sup>41</sup> while by 1985 the figure had risen to 16.5.<sup>42</sup> For obstetrician/gynecologists the average annual claims per 100 practitioners increased from 7.1, before 1981, to 26.6 by 1985.<sup>43</sup> Likewise, malpractice premiums continue to rise. In the three years prior to 1985, there was an average yearly rate hike of 21.9 percent.<sup>44</sup> Naturally, the extremes are well publicized. For example, Long Island neurosurgeons are currently paying over \$83,000 per year for malpractice coverage.<sup>45</sup> Although many of the recent reforms reflect the view that tort law is the source of these problems, the insurance industry, along with its methods of risk

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36. See *infra* notes 40-43 and accompanying text.

37. In 1980, the average award in a medical malpractice case was \$404,726 with verdicts ranging from \$1,708 to approximately \$6.7 million. Telephone interview with Claudia C. Richardson, Research Assistant for Jury Verdict Research, Inc. of Solon, Ohio (Mar. 11, 1987). In 1985, the average award had escalated to almost \$1.2 million with awards ranging from \$5,000 to nearly \$12.7 million. *Id.* In 1986, medical malpractice awards ranged from \$2,500 to \$15,787,555 with an average award amounting to \$1,478,028. Telephone interview with Claudia C. Richardson, Research Assistant for Jury Verdict Research, Inc. of Solon, Ohio (Feb. 2, 1988). Although "averages" may overdramatize the trend in malpractice awards, the figures referred to by Jury Verdict Research as "midpoint verdicts" (half the awards in a given year are greater than this amount and half are less) also reflect this rise. *Id.* The "midpoint verdicts" for 1980, 1985, and 1986 were approximately \$200,000, \$400,000, and \$800,000, respectively. *Id.*

38. See *infra* notes 44-45 and accompanying text.

39. Cf. Posner, *supra* note 1, at 47-48 (disputing the credibility and reliability of data used to support claims of a crisis in malpractice insurance).

40. PROFESSIONAL LIAB. CLEARINGHOUSE, AM. MEDICAL ASS'N CENTER FOR HEALTH POLICY RESEARCH, PROFESSIONAL LIABILITY UPDATE (Dec. 1986) (monthly newsletter discussing data collected during a 1986 survey conducted by the Am. Medical Ass'n's Socioeconomic Monitoring System).

41. *Id.*

42. *Id.*

43. *Id.*

44. *Id.*

45. Meyer, *States Active on Tort Reform Front: New York Physicians Unhappy with Tort Reform Bills*, AM. MED. NEWS, July 11, 1986, at 39.

classification and rate determination, must be critically analyzed for its contribution to the problem.

## II. THE CURRENT CLASSIFICATION SYSTEM

Insurance classification is a method of grouping insured parties based on factors which theoretically ensure that members of the same classification share similar risks.<sup>46</sup> Premiums are then determined based on an averaging of the past statistical experience of the classification group.<sup>47</sup> It is this rate-making approach which predominates among carriers of medical malpractice insurance. For example, St. Paul Fire and Marine Insurance Company, which provides malpractice insurance to approximately 20 percent of the nation's physicians,<sup>48</sup> employs an eight-tier classification scheme ranging from Class 1 physicians who perform no surgical, invasive, or obstetrical procedures, to Class 8 neurosurgeons.<sup>49</sup> While the number of classification groups may vary among carriers,<sup>50</sup> the ba-

46. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403, 408 (1985); Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 517 (1983).

47. See R. MEHR & E. CAMMACK, *PRINCIPLES OF INSURANCE* 646-48 (1972).

48. Telephone interview with Patrick R. Hirigoyen, Senior Communications Specialist for St. Paul Fire and Marine Insurance Co. of St. Paul, Minnesota (Mar. 6, 1987) (unofficial estimate based on information available to The St. Paul Companies).

49. MEDICAL SERVS. DIV., ST. PAUL FIRE & MARINE INS. CO., *PHYSICIANS' AND SURGEONS' UPDATE, AN ANNUAL REPORT FROM THE ST. PAUL 4* (July 1986).

Rating Class	Specialty Definition
1	Physicians—no surgery, no invasive-procedures, no obstetrical procedures
2	Physicians—minor surgery, minor invasive procedures, no obstetrical procedures
3	Family or General Practice—including obstetrical procedures (excluding caesarean sections) Urgent Care Physician—no surgery/Broncho-esophagology/Physicians—major invasive procedures/Surgery—colon and rectal, endocrinology, gastroenterology [sic], geriatrics, neoplastic, nephrology, ophthalmology and urological
4	Family or General Practice—major surgery/Emergency Medicine—no major surgery
5a	Anesthesiologist
5	Emergency Medicine—major surgery/Surgery—abdominal, general, gynecology, hand, head and neck, laryngology, otology, otorhinolaryngology, plastic, plastic-otorhinolaryngology and rhinology
6	Surgery—cardiac, cardiovascular, orthopedic, thoracic, traumatic and vascular
7	Obstetrics/Obstetrics-Gynecology
8	Surgery—Neurological (including child)

*Id.* (Table reproduced in part).

50. For example, Medical Liability Mutual Insurance Co. of New York (MLMIC) uses 14 classifications. *Medical Liab. Mutual Ins. Co., Premium Rate Schedules for Physicians and Surgeons Occurrence & Claims Made Policy Forms* (1986) (became effective July 1, 1986).



sic methodology is the same. Generally, the greater the risk associated with the procedures performed by a specialty group, the higher will be the group's rank and premium payments.<sup>51</sup> However, the premium will frequently be further adjusted based on the geographic region in which the physician practices.<sup>52</sup> Therefore, in this system, losses are distributed across a group whose members share similar risks. Of course, perfect "homogeneity"<sup>53</sup> within a class is not completely possible since there must be enough class members to generate valid statistical inferences.<sup>54</sup>

In determining classifications and their associated rates (premiums), insurance companies consider several objectives. "Rates must be (1) adequate, (2) not unfairly discriminatory, [and] (3) not excessive . . . as a matter of law."<sup>55</sup> To be "adequate" a rate must be sufficient to cover costs arising from claims, as well as offset related business expenditures of the carrier.<sup>56</sup> By ensuring that carriers remain solvent, the policyholder is protected.<sup>57</sup> The second requirement which precludes unfair discrimination refers to "premium differences that do not correspond to expected losses and average expenses or . . . expected average cost differences that are not reflected in premium differences."<sup>58</sup> In this context, "similarly situated" physicians should be similarly charged.<sup>59</sup> Finally, rates assessed by insurers cannot be "excessive."<sup>60</sup> For example, the insurer cannot make an exorbitant profit<sup>61</sup> at the policyholder's expense, or charge rates based on insupportable projections.<sup>62</sup>

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51. *Anzinger v. O'Connor*, 109 Ill. App. 3d 550, 552, 440 N.E.2d 1014, 1016 (1982).

52. Telephone interview with Charles Pinkerton of Pinkerton Insurance Agency, Cleveland, Ohio (agent for The St. Paul Fire and Marine Insurance Co.) (Jan. 2, 1987).

53. Abraham, *supra* note 46, at 417-19.

54. *Id.* at 417. This notion that the size of the classification group is relevant is derived from the "law of large numbers" which implies that "[t]he greater the number of exposures, the more nearly will the actual results obtained approach the probable result expected with an infinite number of exposures." R. MEHR & E. CAMMACK, *supra* note 47, at 33; see also P. DANZON, *supra* note 1, at 89-90 (discussion of the inapplicability of these concepts to medical malpractice insurance).

55. R. MEHR & E. CAMMACK, *supra* note 47, at 642; see *infra* note 63 and accompanying text.

56. R. MEHR & E. CAMMACK, *supra* note 47, at 642.

57. *Id.*

58. Williams, *Unfair Rate Discrimination in Property and Liability Insurance*, in INSURANCE, GOVERNMENT, AND SOCIAL POLICY 212 (S. Kimball & H. Denenberg eds. 1969).

59. *Bentley v. Allstate Ins. Co.*, 227 Ga. 708, 712, 182 S.E.2d 770, 773 (1971) (homeowner's insurance), cited with approval in *Anzinger v. O'Connor*, 109 Ill. App. 3d 550, 559, 440 N.E.2d 1014, 1021 (1982) (medical malpractice insurance).

60. R. MEHR & E. CAMMACK, *supra* note 47, at 644.

61. *Id.*

62. See, e.g., *Medical Malpractice Joint Underwriting Ass'n of Mass. v. Commissioner*

These criteria are frequently dictated by state law and provide a foundation for litigation in this area.<sup>63</sup> In *Anzinger v. O'Connor*,<sup>64</sup> a group of emergency room physicians filed suit against the Director of the Illinois Department of Insurance alleging that their malpractice premiums were "unfairly discriminatory and excessive."<sup>65</sup> The court agreed and held that because the classification of emergency room physicians was not based on the same criteria used to classify other physicians (i.e. procedures performed), the classification was discriminatory.<sup>66</sup> In addition, the court concluded that due to the improper classification, the rates charged were excessive.<sup>67</sup>

While the current rate classification scheme seems to prevail for reasons of efficiency<sup>68</sup> and predictability<sup>69</sup> for the insurer, and for the benefits of risk-spreading for the insured,<sup>70</sup> other approaches are being studied and suggested. Among these proposals is the application of experience rating to medical malpractice insurance.

### III. EXPERIENCE RATING

Experience rating (or merit rating) bases insurance premiums on an individual's actual performance over a period of time.<sup>71</sup> There are several approaches to experience rating such as charging a base premium and then modifying it based on performance "during the policy period."<sup>72</sup> Another method involves looking at the insured's past performance and determining rates accordingly.<sup>73</sup>

Merit rating has been used frequently by the automobile insurance industry.<sup>74</sup> Insurers assess surcharges to drivers with poor records based on accidents and other infractions.<sup>75</sup> Commentators suggest, however, that "accidents" may be just that, and are there-

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of Ins., 395 Mass. 43, \_\_\_, 478 N.E.2d 936, 941, (1985) (requiring that premiums be actuarially sound).

63. See, e.g., ILL. REV. STAT. ch. 73, para. 767.18 (1977), construed in *Anzinger*, 109 Ill. App. 3d at 557-60, 440 N.E.2d at 1020-22.

64. 109 Ill. App. 3d 550, 440 N.E.2d 1014 (1982).

65. *Id.* at 553, 440 N.E.2d at 1017.

66. *Id.* at 559, 440 N.E.2d at 1021.

67. *Id.*

68. See generally Abraham, *supra* note 46 (analysis of efficiency motivations and justifications behind insurance classifications).

69. *Id.*

70. Schwartz & Komesar, *Doctors, Damages and Deterrence*, 298 NEW ENG. J. MED. 1282, 1287 (1978).

71. R. MEHR & E. CAMMACK, *supra* note 47, at 648-50.

72. *Id.* at 650 (termed "retrospective rating").

73. *Id.* at 649-50 (termed "prospective experience rating").

74. See *id.* at 657.

75. Austin, *supra* note 46, at 564.

fore neither deterrable nor indicative of future risks.<sup>76</sup> In other words, it will be of little value to penalize the policyholder in the hope of avoiding conduct over which he/she has little, if any, control, and which says nothing about the driver's propensity for future losses.<sup>77</sup> The response to this criticism is to impose surcharges only for fault-based "accidents."<sup>78</sup> The question then becomes, how one defines "fault" for purposes of experience rating. It is this issue which is fundamental to the applicability of experience rating to medical malpractice insurance.

Theoretically, this approach could provide the best of all possible solutions by maintaining the cohesiveness of group classifications while superimposing the assets of individualization.<sup>79</sup> Those physicians who are causing the problems would be required to pay for them through higher premiums. In a sense, experience rating may be viewed as a supplement to other policing and disciplinary mechanisms used to monitor and control medical malpractice which have been frequently criticized as lax and ineffective<sup>80</sup> (i.e. medical review boards).

If experience rating were applied to medical malpractice insurance, physicians would be assessed surcharges for incidents of "negligence" during a specified period of time, but any such plan must clarify whether *all* claims made against a physician constitute negligence. In addition, planners must consider an experience rating system's applicability to areas of medicine that are prone to greater numbers of claims; in other words, whether physicians in high risk practice areas would be penalized unjustly by a merit system because they engage in high risk specialties and are subject to more claims. Furthermore, the impact of long appeals, the effect of potential reversals of prior determinations of negligence, and whether settlements would be admissions of liability for purposes of experience rating are issues which planners must consider. Undoubtedly these practical considerations and others must be addressed by any

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76. *Id.* at 565-66. "The acknowledgement of the significance of chance in accident involvement undercuts the claims for merit." *Id.* at 565.

77. *Id.* at 565-66.

78. *Id.* at 565.

79. *Id.* at 518. Austin discusses in depth the inherent dichotomy of insurance classification involving the opposing interests of individualism and intragroup unity or "solidarity" as she refers to it. *Id.* at 548-80.

80. S. Wolfe, H. Bergman & G. Silver, *supra* note 3, at 4; cf. Kern, *A Single Lawsuit Could Cost You Your License*, MED. ECON., Jan. 5, 1987, at 58 (describes a recent crackdown among state medical review boards which has resulted in overcompensation for past laxity).

proposal which purports to invoke experience rating in the area of medical malpractice insurance.

#### IV. THE LEGISLATIVE PROPOSALS

While experience rating has not generally been implemented by medical malpractice insurers,<sup>81</sup> it has recently been the subject of insurance regulation and legislation at the state level. On June 12, 1986, the Insurance Department of the State of New York promulgated Regulation No. 124<sup>82</sup> entitled "Physicians and Surgeons Professional Insurance Merit Rating Plan."<sup>83</sup> In Massachusetts, the state legislature has authorized the Commissioner of Insurance to establish a scheme of credits and surcharges based on claims experience for those physicians insured by the Massachusetts Joint Underwriting Association.<sup>84</sup> While both projects are in their infancy, the New York version is at a slightly more advanced stage in its development, having been finally promulgated six months before the Massachusetts plan, which has yet to be actually implemented. It is these efforts at merit rating which will provide the vehicle for analyzing the effects of incorporating this concept into a comprehensive package of medical malpractice reforms.

##### A. *The New York Plan(s)*

Despite 1985 legislation to curb rapidly rising malpractice premiums, New York carriers continued to seek substantial rate hikes.<sup>85</sup> While the insurance industry in some states is kept somewhat in check by a competitive market,<sup>86</sup> in New York, insurance continues to be significantly regulated by the state.<sup>87</sup> In an effort to inject an element of accuracy<sup>88</sup> into the very difficult process of setting rates for medical malpractice insurance, the state adopted a

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81. Rolph, *Some Statistical Evidence on Merit Rating in Medical Malpractice Insurance*, 48 J. RISK & INS. 247, 247 (1981). According to a spokesperson for St. Paul Fire and Marine Insurance Company, a major carrier of malpractice coverage, "[t]he St. Paul has examined so-called 'experience' rating . . . , and has elected not to adopt it. Our underwriters have stated that, for our company, it would not work well with low-frequency, high-severity losses as occur in medical liability, which may take a long time to settle." Letter from Patrick R. Hirigoyen to Lori L. Darling (Jan. 5, 1987).

82. N.Y. COMP. CODES R. & REGS. tit. 11, § 152 (1986).

83. *Id.*

84. 1986 Mass. Acts 351, § 36.

85. *Even Reforms Can't Hold Down Some Malpractice Premiums*, MED. ECON., June 23, 1986, at 13-14.

86. P. DANZON, *supra* note 1, at 95-96.

87. *Id.* at 97.

88. Title 11, § 152.1(a) (Preamble).

novel plan of merit rating its physicians. The purpose of the plan, as described in its Preamble, seems to be enhanced predictability of premiums.<sup>89</sup> By incorporating an individual physician's actual past claims experience into the equation, it is suggested that predictions about the future will be more precise.<sup>90</sup> After reworking its initial proposal in response to criticism from the state medical society,<sup>91</sup> the final version consists of "a system of rules for imposing rate surcharges or credits, within the existing class and territory matrix, based upon an individual's past history of claims or disciplinary actions."<sup>92</sup> Therefore, the New York plan of experience rating does not replace the currently prevailing scheme of classification based on practice specialty and geographic region,<sup>93</sup> but is an adjunct system of further tailoring premiums to the individual insured.

As indicated, the system is triggered by a "claim" or "disciplinary action" against a physician. A "claim" is defined as

written notice or demand upon the insured, including suit, filed by a claimant or other person acting on behalf of the claimant, and received by the insurer, that alleges injuries or damages sustained from an incident. A single incident may result in no more than one chargeable loss for each physician.<sup>94</sup>

A "chargeable loss" refers to the amount of money paid out by the insurer which is of sufficient value to justify an adjustment in a physician's premium.<sup>95</sup>

[F]or claims closed prior to July 1, 1981, the sum of all indemnity payments on any one closed claim must be at least \$15,000; for claims closed or outstanding on or after July 1, 1981, the sum of all indemnity payments on any one closed or outstanding claim must be at least \$30,000.<sup>96</sup>

In addition to chargeable losses, surcharges are also assessed for disciplinary actions against a physician.<sup>97</sup> Such actions include those conducted by the licensing board,<sup>98</sup> as well as proceedings instituted by a hospital.<sup>99</sup> In order of increasing gravity, the plan ap-

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89. *Id.*

90. *Id.* The enhanced capacity to make predictions about the future certainly promotes a fundamental function of insurance rate making. See R. MEHR & E. CAMMACK, *supra* note 47, at 641-42.

91. *This System Rates a Zero With Doctors*, MED. ECON., Mar. 31, 1986, at 11-12.

92. Title 11, § 152.1(a).

93. See *supra* notes 48-52 and accompanying text.

94. Title 11, § 152.2(a).

95. Title 11, § 152.2(b).

96. *Id.*

97. Title 11, § 152.3(b).

98. *Id.* at § 152.3(b)(1).

99. *Id.* at § 152.3(b)(2).

plies a surcharge for state imposed probation, suspension of one's license to practice, or revocation of the same.<sup>100</sup> In terms of hospital proceedings, those which result in a restriction, suspension or termination of hospital privileges based on "malpractice or incompetency"<sup>101</sup> will prompt a surcharge.<sup>102</sup>

The actual procedure of rating physicians according to their experience under the New York plan involves a point system conceptually similar to those used by states to penalize drivers for traffic violations. However, rather than losing one's license after a certain number of points have been generated, the physician pays a higher premium for malpractice coverage. The surcharge is a percentage value of the physician's base rate as determined by his classification and geographic region within the state.<sup>103</sup> In general, a chargeable loss gives rise to a point which in turn prompts a surcharge.<sup>104</sup> The more points accumulated, the greater the percentage of one's base rate which is added to formulate a new, higher premium.<sup>105</sup>

FIGURE 1. EFFECT OF SURCHARGE POINTS ON PREMIUMS OF PHYSICIANS OF VARYING CLASSIFICATIONS

Surcharge Points	1	2	3	4	5	6	7 or More
[Physician Class and Location:]							
1-7 Downstate	0%	0%	10%	35%	80%	130%	200%
8-14 Downstate	0%	10%	35%	70%	110%	150%	200%
1-7 Upstate	0%	10%	35%	70%	110%	150%	200%
8-14 Upstate	5%	15%	45%	85%	120%	160%	200%

Source: N.Y. COMP. CODES R. & REGS. tit. 11, § 152.3(c) (1986).

Disciplinary actions do not generate points, but rather, are treated separately, with each type of proceeding corresponding to an automatic percentage increase.<sup>106</sup>

The events which trigger the system are only relevant if they

100. *Id.* at § 152.3(b)(1). The specific surcharges assessed for these methods of state medical board disciplinary action are 50%, 75%, and 100%, respectively. *Id.*

101. *Id.* at § 152.3(b)(2).

102. *Id.* (Institutional or hospital discipline will result in a surcharge of 75% for suspension or restriction of privileges, and a 100% surcharge for the termination of privileges.).

103. *Id.* at § 152.3(c). For physicians with less than one year's experience, or for those who only practice part-time, a special provision is provided which allows for a reduction in this base rate. *Id.* at § 152.3(d).

104. Title 11, § 152.3(c).

105. *See id.*

106. *See supra* notes 100-02 and accompanying text.

occur within the specified evaluation term.<sup>107</sup> For chargeable losses, the term extends back ten years from the date the insurance contract became effective.<sup>108</sup> Therefore, any chargeable loss payments made during this assessment period are relevant for purposes of experience rating.<sup>109</sup> For disciplinary proceedings, the review spans the five years prior to the date the insurance contract became effective.<sup>110</sup> Physicians who have practiced medicine less than the specified time periods<sup>111</sup> are evaluated on the number of years in practice.<sup>112</sup> Also, claims which span longer than thirteen years from the incident to the settlement will not be used to assess surcharges.<sup>113</sup> Finally, the ultimate restriction on the process is that the maximum allowable surcharge is 200% of the base rate, which is added on to the physician's original premium.<sup>114</sup>

To demonstrate, a class 3 physician who practices downstate, and who has collected four surcharge points, as well as a restriction of his hospital privileges, will be assessed a surcharge of 110% (35% for the points based on his classification and location plus 75% for the restriction of privileges equaling a 110% surcharge which will be added to his base premium).<sup>115</sup> Therefore, if the physician has been paying \$10,000 per year for malpractice coverage, his new rate, after surcharges, will be \$21,000 per year.<sup>116</sup>

In addition to the basic procedure for calculating and assessing surcharges, Regulation No. 124 directs that the physician receive adequate notice<sup>117</sup> of the surcharge and an opportunity to challenge the results.<sup>118</sup> This appeals process enables the physician to offer an explanation for the events which lead to a surcharge.<sup>119</sup> The plan does not specify the details of the appellate procedure, but rather, leaves the matter to the discretion of the insurer, subject to the ap-

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107. Title 11, § 152.3(a).

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.* These "older" occurrences are excluded as bases for surcharge even if the insurer pays the claim during the evaluation term. *Id.* Presumably, this represents New York's effort to confine the parameters of merit rating to a period of relatively recent history in a physician's career.

114. Title 11, § 152.3(c).

115. *Id.* See *supra* p. 267 (chart) & note 102.

116. *Id.*

117. Title 11, § 152.3(h).

118. *Id.* at § 152.3(e).

119. *Id.*

proval of the Insurance Department.<sup>120</sup> It is indicated that "[s]urcharge 'points' shall be waived or reduced by insurers if circumstances indicate that they are not truly predictive of future claims."<sup>121</sup> If it is ultimately determined that a physician is entitled to a refund, then the refund shall include the surcharge paid for the current policy term, as well as the two previous terms if appropriate (i.e. where unwarranted surcharges had been paid by the physician during the two prior terms).<sup>122</sup>

In response to the New York Insurance Department Plan, Medical Liability Mutual Insurance Company of New York (MLMIC), the largest physician-owned insurance company in the nation,<sup>123</sup> submitted its own merit rating proposal which was approved by the Department for a one year trial basis.<sup>124</sup> During this time, the company will collect data and document the efficacy of its proposal<sup>125</sup> for ultimate review by the state Superintendent of Insurance.<sup>126</sup> The fundamental difference between the MLMIC plan and the state's plan is the former's emphasis on individualized review of physicians on a case-by-case basis.<sup>127</sup> Review is triggered by a variety of occurrences. It will be automatic for disciplinary actions,<sup>128</sup> it may be prompted by claims experience<sup>129</sup> and can also be initiated by "[a] physician member of the Company's Claim Review Committee . . . based on his judgment that the methods of practice of a policyholder have fallen below acceptable standards in one or more Claims or Suits."<sup>130</sup> If review is indicated, it will be performed by one of two panels,<sup>131</sup> both of which include physician members.<sup>132</sup> For Medical Society members, the Professional Medical Liability Insurance and Defense Board will review the physician for a potential surcharge, whereas for non-members, the MLMIC

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120. *Id.*

121. *Id.*

122. *Id.* at § 152.3(f).

123. Telephone interview with Shirley Connell, MLMIC Public Relations (Jan. 5, 1987) [hereinafter Connell interview I]. MLMIC insures approximately three-quarters of the physicians in New York State. Meyer, *supra* note 45, at 39.

124. Connell interview I, *supra* note 123.

125. *Id.*

126. See MED. LIAB. MUTUAL INS. CO., PHYSICIANS AND SURGEONS PROFESSIONAL MERIT RATING PLAN 4 (1986) [hereinafter MLMIC PLAN].

127. Connell interview I, *supra* note 123.

128. MLMIC PLAN, *supra* note 126, at 1.

129. *Id.* at 1-2.

130. *Id.* at 3.

131. *Id.*

132. Connell interview I, *supra* note 123.



Claims Review Committee will perform an identical function.<sup>133</sup> The purpose of these review committees is to evaluate the physician and make appropriate recommendations to the insurer.<sup>134</sup> This approach allows not only for the imposition of a surcharge (ranging from 25% to 200% of the base premium),<sup>135</sup> but other remedial measures as well, such as educational programs for the physician-insured.<sup>136</sup> MLMIC contends such flexibility and subjectivity are essential to its plan, distinguishing it from the more mechanical state version of experience rating.<sup>137</sup>

### B. *The Massachusetts Legislation and Debate*

On January 1, 1987, Section 36 of Chapter 351,<sup>138</sup> which was enacted in July, 1986, as part of a diversified scheme of medical malpractice reforms,<sup>139</sup> became effective. This Section enables the Massachusetts Commissioner of Insurance to institute a procedure, whereby physicians insured by the Joint Underwriting Association<sup>140</sup> would be subject to credits and surcharges.<sup>141</sup>

Said system shall provide for surcharges to be imposed on all physicians insured by the association [JUA] whose claims in the previous five years exceed in number the average number of claims asserted against physicians in their specialty. Such surcharges each year for a physician shall be calculated on an actuarially sound basis to reflect the *increased cost of defending physicians with more claims asserted against them than the average* in their specialty. . . . Said system shall further provide for credits to be given to all physicians insured by the association [JUA] who have not had a civil action commenced against them for malpractice, error or mistake in the provision or failure to provide medical or surgical services during their practice in the

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133. MLMIC PLAN, *supra* note 126, at 3. The purpose of this dual-track review process is to satisfy a preference of Medical Society members to be evaluated under their own peer review system, and a similar preference by non-members to be reviewed by an unaffiliated panel of their peers. Telephone interview with Shirley Connell, MLMIC Public Relations (Jan. 9, 1987) [hereinafter Connell interview II].

134. MLMIC PLAN, *supra* note 126, at 3.

135. *Id.*

136. *Id.*

137. Connell interview I, *supra* note 123.

138. 1986 Mass. Acts 351, § 36.

139. Telephone interview with Richard W. Moore, Executive Director of the Joint Underwriting Association of Massachusetts (Jan. 5, 1987) [hereinafter Moore interview I].

140. Of the 17,000 Massachusetts physicians, the Joint Underwriting Association provides coverage for 11,000. Rust, *MDs in Massachusetts Troubled by New 'Cap': Liability Costs to Rise for Some Massachusetts MDs*, AM. MED. NEWS, Aug. 1, 1986, at 29; see *supra* notes 18-19 and accompanying text for a general discussion of joint underwriting associations.

141. 1986 Mass. Acts 351, § 36.

commonwealth over a time period which the commissioner by regulation shall determine.<sup>142</sup>

Although this legislation lays the groundwork for the creation of an experience rating plan in Massachusetts, the actual procedure to be used is still the subject of hearings and debate.<sup>143</sup> Currently, the Massachusetts Medical Society is at the forefront of the debate with suggestions for a plan that will meet the concerns of the medical community.<sup>144</sup> Initially, it was suggested that as an arguable matter of statutory interpretation, the legislation did not require the implementation of merit rating, but rather created that option for the Commissioner of Insurance.<sup>145</sup> A number of issues arise from the existing merit rating plans and current discussion in states such as Massachusetts which are investigating the impact this insurance reform might have on the medical malpractice dilemma. These issues are the focus of the following analysis.

## V. ANALYSIS

In order to effectively evaluate the merit rating alternative, the practical and theoretical rationales for its implementation must first

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142. *Id.* (emphasis added).

143. Telephone interview with Richard W. Moore, Executive Director of Joint Underwriting Association of Massachusetts (Nov. 5, 1987) [hereinafter Moore interview II]. Since Massachusetts' new malpractice law became effective in January, 1987, the controversy has focused on selecting a plan for implementation and determining the extent to which such a plan must conform to the specifics of the enabling legislation. The divergent proposals on the table are supplied by the Massachusetts Medical Society and the State Rating Bureau (SRB). The Medical Society seeks a highly subjective approach referred to as a "doctors' judgment plan" which imposes a surcharge after a two-tier peer review has determined that a patient injury was the result of fault or actual malpractice. Under this system, the physician enjoys a significant amount of due process via assessment by his peers and an opportunity for discussion prior to a surcharge. The SRB argues that such a plan does not comply with the guidelines provided in Section 36 of Chapter 351. Principally, the Medical Society proposal does not incorporate a mechanism for ensuring that physicians who have more than the average number of claims against them (as compared to other members of their specialty) are surcharged regardless of fault.

The SRB plan is based on the premise that fault is of no consequence. The theory is that the frequency of claims is the most significant criteria. The more claims against a physician, the more time and money that must be expended by the insurer on his or her behalf. Therefore, this approach adopts a point system whereby an automatic mandatory surcharge is generated by a claim which need not be a closed claim. It is suggested by proponents of this plan that lawsuits or claims correlate with the likelihood of subsequent claims and are therefore justifiably surchargeable events. As of the writing of this Note more hearings are planned to reconcile the issues of experience rating of physicians in Massachusetts. *Id.*

144. *Id.* See *infra* notes 177-78 and accompanying text.

145. Moore interview I, *supra* note 139. At present, Massachusetts is committed to the adoption of some form of merit rating, the specifics of which have yet to be finalized. Moore interview II, *supra* note 143.

be understood. From the perspective of the insured, experience rating is a means of individualizing the rate setting process.<sup>146</sup> If the inference that there is some logical correlation between an insured's past and future claims experience is justified,<sup>147</sup> then merit rating may be instituted in order to improve accuracy and predictability.<sup>148</sup> This underlying correlation between past and future experience is, however, debatable.<sup>149</sup> Danzon disputes suggestions that malpractice is random, as are the claims filed and the decisions rendered by the courts.<sup>150</sup> If these notions of malpractice as haphazard events were to be accepted, merit rating would seemingly not be justified. If claims are random, then past experience would have no actuarial bearing on the likelihood of future problems.<sup>151</sup> However, proponents have indicated that based on the available data, there is in fact a correlation.<sup>152</sup> Therefore, it may be argued that merit rating, for purposes of improving accuracy and predictability of premiums, is a sensible alternative.

Perhaps more significant justifications for experience rating involve the fundamental tort concepts of "punishment" and "deterrence."<sup>153</sup> "Punishment" may be a harsh misnomer for what really is a rationale derived from equitable principles.<sup>154</sup> In other words, fairness dictates that physicians who are negligent should pay more than those who are not.<sup>155</sup> Physicians with good records should not be penalized by having to continually finance the losses of those with poor claims experience.<sup>156</sup> Merit rating can be viewed as a supplement to a currently inefficient and ineffective mechanism of

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146. See Schwartz & Komesar, *supra* note 70, at 1287; cf. Rolph, *supra* note 81, at 255-56 (individualization of premiums may also be desirable from the insurer's perspective).

147. Rolph, *supra* note 81, at 259.

148. See *id.* at 256-57.

149. See *supra* notes 76-78 and accompanying text.

150. P. DANZON, *supra* note 1, at 130; see also Schwartz & Komesar, *supra* note 70, at 1287; Rolph, *supra* note 81, at 259; C. Phelps, Experience Rating in Medical Malpractice Insurance 5 (June 1978) (unpublished manuscript issued by The Rand Corporation in which statistical justification for experience rating is proffered).

151. But see sources cited *supra* note 150.

152. See sources cited *supra* note 150.

153. Schwartz & Komesar, *supra* note 70, at 1282-83, 1287, 1289; P. DANZON, *supra* note 1, at 86-87 (this notion of "deterrence" is a recurring foundation of analysis used by the author to justify and/or discredit a variety of potential malpractice reforms including experience rating); see also Austin, *supra* note 46, at 567 (discussion of punishment and deterrence in terms of merit rating automobile insurance).

154. See P. DANZON, *supra* note 1, at 250, n. 5.

155. See *id.*

156. *Id.* ("experience-rated premiums have appeal on grounds of equity: without experience rating, good risks effectively subsidize bad risks"); S. Wolfe, H. Bergman & G. Silver, *supra* note 3, at iii, 4 (urging the adoption of experience-rated premiums so that good doctors

physician discipline.<sup>157</sup> Since many states have failed to deal cogently with the alleged *source* of the medical malpractice crisis—the negligent practitioner—perhaps a system of merit rating will achieve the desired result by surcharging the incompetent physicians out of practice.<sup>158</sup>

It is certainly an acceptable function of the insurance industry to promote loss avoidance.<sup>159</sup> Under merit rating, the insured can be encouraged to prevent losses since he/she is rewarded by lower premiums.<sup>160</sup> It is conceivable that merit rating restores the deterrent effect of the tort liability system that is diminished, if not destroyed, by liability insurance.<sup>161</sup> Theoretically, malpractice insurance shields the physician from the financial impositions of the tort system.<sup>162</sup> However, this argument may only be significant if the other, perhaps more secondary, penalties associated with being sued for medical malpractice are inconsequential.<sup>163</sup> The personal, reputational and career ramifications of a lawsuit would arguably have as powerful an effect on medical malpractice avoidance, as would the imposition of financial sanctions.<sup>164</sup> It seems that few physicians (or their employers) are ambivalent about the threat of a lawsuit even when the bulk of the monetary sanctions are paid by the insurer. A claim of malpractice reflects negatively on a physician's skill and reputation which are important tools of his or her

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will stop subsidizing the few doctors with poor performance records); cf. Abraham, *supra* note 46, at 430.

157. See *supra* note 80 and accompanying text.

158. S. Wolfe, H. Bergman & G. Silver, *supra* note 3, at i-iii, 1, 4, 5 (insufficient state discipline of practitioners has created the medical malpractice crisis); C. Phelps, *supra* note 150, at 1; *Curbing the Cost of Medical Malpractice Insurance* (WCBV-TV Boston, Channel 5, May 1, 1985) (transcript of editorial available from the Massachusetts Legislature, Committee on Insurance, Boston, Massachusetts) ("Insurance companies should charge rates which reflect a doctor's track record. Higher rates for more claims paid works for drivers; why not try it for physicians as well? The high cost of medical malpractice insurance is a problem. But the legislature should treat the cause and not the symptoms.").

159. R. MEHR & E. CAMMACK, *supra* note 47, at 645.

160. See P. DANZON, *supra* note 1, at 122 (Reductions in an insured's premiums commensurate with the insured's expenses in providing himself a lower risk of loss protect the incentives to invest in loss-reduction measures).

161. *Id.* at 5, 86-87, 130; Schwartz & Komesar, *supra* note 70, at 1282, 1287, 1289 (malpractice insurance interferes with the deterrent function of the tort system unless premiums are experience-rated).

162. P. DANZON, *supra* note 1, at 5, 86, 130; Robinson, *Rethinking the Allocation of Medical Malpractice Risks Between Patients and Providers*, 49 LAW & CONTEMP. PROBS. 173, 176 (1986); Schwartz & Komesar, *supra* note 70, at 1287 (liability insurance insulates defendants from the economic costs of liability designed to constrain risk-creating activity).

163. Schwartz & Komesar, *supra* note 70, at 1287-88; cf. P. DANZON, *supra* note 1, at 129 (places greater emphasis on the impact of these intangibles).

164. P. DANZON, *supra* note 1, at 129; Robinson, *supra* note 162, at 176-77.

trade. Perhaps even more devastating than the harm to one's good name is the impact of malpractice on a physician's potential for career advancement. Certainly, malpractice claims against a staff physician are not taken lightly by a hospital employer and the physician's supervisors (nor should they be). A physician could be refused promotion or perhaps lose institutional practice privileges. Therefore, the economic disincentive to malpractice created by the threat of a lawsuit still exists despite the protection afforded by insurance because the physician's livelihood may be at stake.

Further insight into the deterrent rationale may be achieved by a comparison to automobile insurance which uses merit rating, at least in part, for this purpose.<sup>165</sup> While deterrence may be a reasonable pursuit for both medical malpractice and automobile insurers, the ramifications may differ. The individual driver who is subject to merit rating of premiums will theoretically be motivated to avoid accidents, and the associated insurance rate hikes.<sup>166</sup> Even if this motivation holds true for physicians (which arguably it does not), the implications for third parties differ, and may not be equally positive. When the driver modifies his behavior to avoid losses, there is little concern that one can be too careful on the road. On the other hand, a physician's effort to avoid malpractice and resulting surcharges may encourage overly cautious or "defensive medicine" and adversely affect patients.<sup>167</sup> If a physician approaches a seriously ill patient with such caution that it borders on trepidation, neither the patient, nor the practice of medicine will benefit. Advances in medicine require that some risks be taken. If merit rating is to be successfully applied to medical malpractice as a means of modifying the behavior of those who take unacceptable risks with patients, care must be taken so as not to also deter those physicians

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165. *Mass. Auto. Rating & Accident Prevention Bureau v. Commissioner of Ins.*, 384 Mass. 333, 424 N.E.2d 1127 (1981). "The [insurance] industry challenges the Commissioner's finding that the deterrent effect of the merit rating program will reduce the frequency of property damage and collision claims. . . . [However,] there was reasonable support in the record for the Commissioner's decision to accept [this] approach. . . ." *Id.* at 338-39, 424 N.E.2d at 1130-31; see also *Mass. Auto. Rating & Accident Prevention Bureau v. Commissioner of Ins.*, 381 Mass. 592, 600-01, 411 N.E.2d 762, 767 (1980) (acknowledges deterrence rationale of merit rating).

166. See cases cited *supra* note 165.

167. Schwartz & Komesar, *supra* note 70, at 1286, 1289; see SOCIOECONOMIC MONITORING SYSTEM, AMA CENTER FOR HEALTH POLICY RESEARCH, SMS REPORT, RECENT TRENDS IN MEDICAL PROFESSIONAL LIABILITY (Mar. 1985) [hereinafter SMS REPORT] (provides data supporting claims of defensive practice); see also *Texas Liability Survey Shows Physicians Limiting Practices, Adding Tests and Procedures*, AM. MED. NEWS, Jan. 9, 1987, at 12 (Texas study reveals procedures added to avoid lawsuits); but see Robinson, *supra* note 162, at 176-78. "[E]vidence of defensive medicine is notoriously unreliable." *Id.* at 177.

who take risks which may cure patients and advance medical knowledge.<sup>168</sup> Other values must not be sacrificed in order that deterrence be enhanced. The potential for defensive medicine not only creates problems for the individual patient whose care might be compromised,<sup>169</sup> but may also result in broader ramifications for health care delivery.

For example, while the incompetent physician may be justifiably ousted from practice by an experience rating which makes insurance unaffordable, many good physicians may also elect to leave practice.<sup>170</sup> The high-risk specialties and litigious regions of the country may experience a flight of physicians and eventual shortages.<sup>171</sup> There will be little incentive for these physicians to practice in states like New York and Massachusetts which impose malpractice surcharges when those physicians can practice elsewhere without these burdens.<sup>172</sup> However, physician flight is not an unavoidable result if the merit rating system provides an incentive for competent physicians to remain by offering them lower base premiums (i.e. pre-surge rates) than those their colleagues are forced to pay under non-experience rated plans in other states. If an exodus of physicians does occur, it is arguable that the negligent practitioners will leave in the greatest numbers since they stand to lose the most by a system of surcharges. Therefore, from the perspective of states which elect to impose experience rating, this "exodus" may be perceived as a significant, albeit secondary, advantage of such an approach. Even if physicians do not leave, they may modify their behavior by refusing to accept patients with certain high risk diagnoses.<sup>173</sup> Finally, the monetary costs generated by de-

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168. See *supra* notes 159-61 and accompanying text. Physicians in the high risk specialties will likely feel most vulnerable under a system of experience rating. Even if competent and cautious, those doctors who care for patients necessitating innovative medical treatment will presumably be sued more often. However, proponents of experience rating may argue that these physicians will not be penalized. In effect, the "best" doctors in a high risk classification group will enjoy a break in their premiums for the first time.

169. See SMS REPORT, *supra* note 167. "[N]egative defensive medicine," occurs when a physician avoids certain procedures because legal risks might arise from resulting complications." *Id.*

170. Rosenbloom & Stone, *Social Aspects of the Rate Structure of Medical Malpractice Insurance*, J. RISK & INS. 53, 59-60 (1978).

171. *Id.* at 60; but see ABA COMM., *supra* note 1, at 33 (shortage allegations unwarranted).

172. See Rosenbloom & Stone, *supra* note 170, at 59-60; but see ABA COMM., *supra* note 1, at 33. It may be arguable in the alternative that a redistribution of physicians prompted by surcharge avoidance may be a positive ramification of merit rating.

173. Rosenbloom & Stone, *supra* note 170, at 59; See also P. DANZON, *supra* note 1, at 130-31; Schwartz & Komesar, *supra* note 70, at 1289.

fensive medicine are well documented, as is the awareness that these costs will be passed on to patients.<sup>174</sup> Therefore, a merit rating plan which acknowledges that some risks are acceptable, and that a lawsuit or "closed claim" does not *always* reflect surchargeable incompetence, must be pursued.<sup>175</sup>

The optimal system requires some form of subjectivity as is incorporated into the MLMIC Plan, rather than plugging cold data into an unyielding equation of credits and debits.<sup>176</sup> As urged by some members of the medical community, it would seem that physicians themselves must actively participate in the subjective review process if experience rating is to succeed.<sup>177</sup> Any plan which purports to affect a group as powerful as the medical community would be wise to incorporate their involvement or confront vehement resistance. According to Kenneth A. Heisler, M.D. of the Massachusetts Medical Society in testimony before the Massachusetts Joint Committee on Insurance,

[s]uccessful experience rating and risk management programs necessarily involve professional medical judgments, rather than arbitrary actions based on statistics. The Commissioner of Insurance has great expertise in regulating insurance companies, but he is not involved in regulating the practice of medicine. . . . Active, effective support is unlikely to result if the programs are imposed from outside the medical profession. . . .<sup>178</sup>

Employing a peer review system where physicians evaluate the claims experience of fellow practitioners should temper some of the concerns associated with rigid variables such as "closed claims" and "chargeable losses."<sup>179</sup> In other words, physician participation avoids burdening practitioners with *unwarranted* surcharges.<sup>180</sup> Therefore, problems with deciding *what* constitutes "negligence" for purposes of assessing surcharges might be ameliorated.<sup>181</sup>

The risk that physicians will be unable to police themselves, as has frequently been the case with medical review boards, may not

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174. Rosenbloom & Stone, *supra* note 170, at 60; see also P. DANZON, *supra* note 1, at 147; Robinson, *supra* note 162, at 178.

175. Connell interview II, *supra* note 133; see also Kern, *supra* note 80, at 60.

176. Connell interview I, *supra* note 123; see also P. DANZON, *supra* note 1, at 129.

177. Hearing, *supra* note 34 (testimony of Kenneth A. Heisler, M.D. before the Massachusetts Insurance Commission).

178. *Id.*

179. See P. DANZON, *supra* note 1, at 134-35.

180. Connell interview II, *supra* note 133; P. DANZON, *supra* note 1, at 129, 251 n.12.

181. Connell interview I, *supra* note 123; P. DANZON, *supra* note 1, at 251 n.12. For example, when a case is settled by the insurer without a trial, or reversed on appeal, whether a surcharge is imposed would be a matter for deliberation by the review committee. Connell interview II, *supra* note 133.

be a problem if the insurance company is a physician-owned mutual or *employs* physician specialists for the purpose of experience rating review.<sup>182</sup> The reviewing physicians' financial stake in the outcome (as a representative of the insurer) may balance the professional bias he/she is likely to have.<sup>183</sup>

While the subjective component built into the merit rating process avoids the unfairness associated with a rigid approach to merit rating, it may also create a significant bias. The subjective review which determines whether to attach a surcharge or not would in essence be performed by the insurer. Arguably, this may render the review process less than impartial since the insurer obviously seeks to benefit if a surcharge is imposed.<sup>184</sup> A similar analysis reveals what is perhaps the most significant potential problem; insurer conflict of interest. It is conceivable that insurers will be increasingly motivated to settle rather than defend against frivolous claims<sup>185</sup> or smaller claims they could likely win in litigation. It is clear that in some cases the insurer will be encouraged to recoup at least some of its costs by surcharging the physician rather than face the costs of litigating a physician's potentially winning case. Thus, it may be very difficult for the insurer to safeguard both the interests of the physician-insured and its own economic interests. The potential for abuse may also be great based on the power granted the insurer with a given scheme of merit rating.

### CONCLUSION

The problem of soaring medical malpractice premiums has been addressed with a variety of proposed solutions. The most pervasive response to the malpractice crisis has been in the realm of state tort law reforms which have seemingly failed to rectify the insurance component of the malpractice dilemma. Insurers continue to abandon the medical malpractice line of coverage and rates continue to escalate.

A novel approach to the problem, experience rating of physicians, adapts a familiar form of insurance rate determination to an

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182. See *supra* notes 157-58 and accompanying text; see P. DANZON, *supra* note 1, at 128-29, 134-35.

183. See generally P. DANZON, *supra* note 1, at 134-35 (advocates review by medical society members).

184. The proposed plans under consideration in Massachusetts are "revenue neutral." In other words, surcharges are designed to cover costs, not to extract a profit at the insured's expense. Moore interview II, *supra* note 143.

185. See P. DANZON, *supra* note 1, at 135.



area of insurance which, as a rule, has not used this technique. This approach provides a partial solution by enabling insurers to surcharge those physicians who are burdening both the system and their colleagues because of costly malpractice claims. Two of the states which are trying this approach are New York and Massachusetts.

The state of New York plan mechanically imposes surcharges for "claims" and "disciplinary actions." The plan is criticized because physicians have no input in the decision-making process. The MLMIC approach addresses this concern by incorporating physician participation into the process of determining which claims and lawsuits reflect surchargeable incompetence. Unlike the state's plan, the imposition of a surcharge is not a knee jerk response to a claim. Injecting this subjective component into the system furthers two important objectives. First, physicians pay a surcharge only when it is fair that they do so. Second, the medical community is likely to support a rating system that allocates a degree of control over the surcharge determination process to physicians. Although the future of experience rating plans is uncertain, the subjectivity which the MLMIC plan advocates may influence which plan, if either, will prove to be the plan of choice.

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